



**Independence
Blue Cross**

**Prior Authorization Form
Xolair® (omalizumab)**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Xolair®

Quantity _____ Refill x _____ months

Instructions _____

Physician's signature _____ Provider NPI: _____ MD# _____

Date: _____ Date medication needed _____

Patient Information

Patient's name _____

Patient's address _____

City, State, Zip: _____

Patient's phone # _____

Patient's ID#: _____ DOB _____

Prescriber Information

Prescribing physician _____

Office address _____

City, State, Zip: _____

Office contact _____

Office # _____ Fax# _____

Upon approval, delivery is available. Complete section below.

No Delivery Requested

Delivery Requested

Physician Supply, authorization only [Flex series]

Physician's office

Patient's home

Member Pick up at pharmacy if benefit available

Preferred Vendor: _____

****A copy of the prescription must accompany the medication request****

1. PHYSICIAN'S SPECIALTY (required, specify all) _____

2. DIAGNOSIS FOR DRUG REQUESTED

Moderate to severe asthma

Other (specify) _____

3. PATIENT'S INFORMATION:

a. Has the patient had a positive skin test or in vitro reactivity to a perennial aeroallergen? Yes No N/A

b. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids? Yes No N/A

c. Has the patient failed, is unresponsive to, or inadequately controlled on inhaled corticosteroids in combination with a long-acting beta agonist? Yes No N/A

d. Does the patient have a baseline serum IgE level between 30 IU/ml and 700 IU/ml? Yes No N/A

4. PATIENT HISTORY

New start Continued Treatment

Please list any previous or current therapies related to the diagnosis:

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**